

REFERENCE TITLE: AHCCCS; health insurance; children

State of Arizona
Senate
Forty-eighth Legislature
First Regular Session
2007

SB 1440

Introduced by
Senator Allen

AN ACT

AMENDING SECTIONS 36-2912, 36-2982, 36-2983 AND 36-2988, ARIZONA REVISED
STATUTES; RELATING TO THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 36-2912, Arizona Revised Statutes, is amended to
3 read:

4 36-2912. Healthcare group coverage: program requirements for
5 small businesses and public employers: related
6 requirements: definitions

7 A. The administration shall administer a healthcare group program to
8 allow willing contractors to deliver health care services to persons defined
9 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),
10 (d) and (e). In the absence of a willing contractor, the administration may
11 contract directly with any health care provider or entity. The
12 administration may enter into a contract with another entity to provide
13 administrative functions for the healthcare group program.

14 B. Employers with one eligible employee or up to an average of fifty
15 eligible employees under section 36-2901, paragraph 6, subdivision (d):

16 1. May contract with the administration to be the exclusive health
17 benefit plan if the employer has five or fewer eligible employees and enrolls
18 one hundred per cent of these employees into the health benefit plan.

19 2. May contract with the administration for coverage available
20 pursuant to this section if the employer has six or more eligible employees
21 and enrolls eighty per cent of these employees into the healthcare group
22 program.

23 3. Shall have a minimum of one and a maximum of fifty eligible
24 employees at the effective date of their first contract with the
25 administration.

26 C. The administration shall not enroll an employer group in healthcare
27 group sooner than one hundred eighty days after the date that the employer's
28 health insurance coverage under an accountable health plan is discontinued.
29 Enrollment in healthcare group is effective on the first day of the month
30 after the one hundred eighty day period. This subsection does not apply to
31 an employer group if the employer's accountable health plan discontinues
32 offering the health plan of which the employer is a member.

33 D. Employees with proof of other existing health care coverage who
34 elect not to participate in the healthcare group program shall not be
35 considered when determining the percentage of enrollment requirements under
36 subsection B of this section if either:

37 1. Group health coverage is provided through a spouse, parent or
38 legal guardian, or insured through individual insurance or another employer.

39 2. Medical assistance is provided by a government subsidized health
40 care program.

41 3. Medical assistance is provided pursuant to section 36-2982,
42 subsection ~~I~~ H.

43 E. An employer shall not offer coverage made available pursuant to
44 this section to persons defined as eligible pursuant to section 36-2901,

1 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally
2 designated plan.

3 F. An employee or dependent defined as eligible pursuant to section
4 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in
5 healthcare group on a voluntary basis only.

6 G. Notwithstanding subsection B, paragraph 2 of this section, the
7 administration shall adopt rules to allow a business that offers healthcare
8 group coverage pursuant to this section to continue coverage if it expands
9 its employment to include more than fifty employees.

10 H. The administration shall provide eligible employees with disclosure
11 information about the health benefit plan.

12 I. The director shall:

13 1. Require that any contractor that provides covered services to
14 persons defined as eligible pursuant to section 36-2901, paragraph 6,
15 subdivision (a) provide separate audited reports on the assets, liabilities
16 and financial status of any corporate activity involving providing coverage
17 pursuant to this section to persons defined as eligible pursuant to section
18 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

19 2. Beginning on July 1, 2005, require that a contractor, the
20 administration or an accountable health plan negotiate reimbursement rates
21 and not use the administration's reimbursement rates established pursuant to
22 section 36-2903.01, subsection H, ~~as~~ as a default reimbursement rate if a
23 contract does not exist between a contractor and a provider.

24 3. Use monies from the healthcare group fund established by section
25 36-2912.01 for the administration's costs of operating the healthcare group
26 program.

27 4. Ensure that the contractors are required to meet contract terms as
28 are necessary in the judgment of the director to ensure adequate performance
29 by the contractor. Contract provisions shall include, at a minimum, the
30 maintenance of deposits, performance bonds, financial reserves or other
31 financial security. The director may waive requirements for the posting of
32 bonds or security for contractors that have posted other security, equal to
33 or greater than that required for the healthcare group program, with the
34 administration or the department of insurance for the performance of health
35 service contracts if funds would be available to the administration from the
36 other security on the contractor's default. In waiving, or approving waivers
37 of, any requirements established pursuant to this section, the director shall
38 ensure that the administration has taken into account all the obligations to
39 which a contractor's security is associated. The director may also adopt
40 rules that provide for the withholding or forfeiture of payments to be made
41 to a contractor for the failure of the contractor to comply with provisions
42 of its contract or with provisions of adopted rules.

43 5. Adopt rules.

6. Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

J. With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

K. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall provide a health benefit plan to each small employer without regard to health status-related factors if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan and contract. The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

- (a) The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.

- (b) Renewability of coverage.

- (c) Any preexisting condition exclusion.

- (d) The geographic areas served by the contractor.

2. The benefits and premiums available under all health benefit plans for which the employer is qualified.

L. The administration shall describe the information required by subsection K of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

1 M. A contractor is not required to disclose any information that is
2 proprietary and protected trade secret information under applicable law.

3 N. At least sixty days before the date of expiration of a health
4 benefit plan, the administration shall provide a written notice to the
5 employer of the terms for renewal of the plan.

6 O. The administration may increase or decrease premiums based on
7 actuarial reviews of the projected and actual costs of providing health care
8 benefits to eligible members. Before changing premiums, the administration
9 must give sixty days' written notice to the employer. The administration may
10 cap the amount of the change.

11 P. The administration may consider age, sex, income and community
12 rating when it establishes premiums for the healthcare group program.

13 Q. Except as provided in subsection R of this section, a health
14 benefit plan may not deny, limit or condition the coverage or benefits based
15 on a person's health status-related factors or a lack of evidence of
16 insurability.

17 R. A health benefit plan shall not exclude coverage for preexisting
18 conditions, except that:

19 1. A health benefit plan may exclude coverage for preexisting
20 conditions for a period of not more than twelve months or, in the case of a
21 late enrollee, eighteen months. The exclusion of coverage does not apply to
22 services that are furnished to newborns who were otherwise covered from the
23 time of their birth or to persons who satisfy the portability requirements
24 under this section.

25 2. The contractor shall reduce the period of any applicable
26 preexisting condition exclusion by the aggregate of the periods of creditable
27 coverage that apply to the individual.

28 S. The contractor shall calculate creditable coverage according to the
29 following:

30 1. The contractor shall give an individual credit for each portion of
31 each month the individual was covered by creditable coverage.

32 2. The contractor shall not count a period of creditable coverage for
33 an individual enrolled in a health benefit plan if after the period of
34 coverage and before the enrollment date there were sixty-three consecutive
35 days during which the individual was not covered under any creditable
36 coverage.

37 3. The contractor shall give credit in the calculation of creditable
38 coverage for any period that an individual is in a waiting period for any
39 health coverage.

40 T. The contractor shall not count a period of creditable coverage with
41 respect to enrollment of an individual if, after the most recent period of
42 creditable coverage and before the enrollment date, sixty-three consecutive
43 days lapse during all of which the individual was not covered under any
44 creditable coverage. The contractor shall not include in the determination
45 of the period of continuous coverage described in this section any period

1 that an individual is in a waiting period for health insurance coverage
 2 offered by a health care insurer or is in a waiting period for benefits under
 3 a health benefit plan offered by a contractor. In determining the extent to
 4 which an individual has satisfied any portion of any applicable preexisting
 5 condition period, the contractor shall count a period of creditable coverage
 6 without regard to the specific benefits covered during that period. A
 7 contractor shall not impose any preexisting condition exclusion in the case
 8 of an individual who is covered under creditable coverage thirty-one days
 9 after the individual's date of birth. A contractor shall not impose any
 10 preexisting condition exclusion in the case of a child who is adopted or
 11 placed for adoption before age eighteen and who is covered under creditable
 12 coverage thirty-one days after the adoption or placement for adoption.

13 U. The written certification provided by the administration must
 14 include:

15 1. The period of creditable coverage of the individual under the
 16 contractor and any applicable coverage under a COBRA continuation provision.

17 2. Any applicable waiting period or affiliation period imposed on an
 18 individual for any coverage under the health plan.

19 V. The administration shall issue and accept a written certification
 20 of the period of creditable coverage of the individual that contains at least
 21 the following information:

22 1. The date that the certificate is issued.

23 2. The name of the individual or dependent for whom the certificate
 24 applies and any other information that is necessary to allow the issuer
 25 providing the coverage specified in the certificate to identify the
 26 individual, including the individual's identification number under the policy
 27 and the name of the policyholder if the certificate is for or includes a
 28 dependent.

29 3. The name, address and telephone number of the issuer providing the
 30 certificate.

31 4. The telephone number to call for further information regarding the
 32 certificate.

33 5. One of the following:

34 (a) A statement that the individual has at least eighteen months of
 35 creditable coverage. For THE purposes of this subdivision, "eighteen months"
 36 means five hundred forty-six days.

37 (b) Both the date that the individual first sought coverage, as
 38 evidenced by a substantially complete application, and the date that
 39 creditable coverage began.

40 6. The date creditable coverage ended, unless the certificate
 41 indicates that creditable coverage is continuing from the date of the
 42 certificate.

43 W. The administration shall provide any certification pursuant to this
 44 section within thirty days after the event that triggered the issuance of the

1 certification. Periods of creditable coverage for an individual are
2 established by presentation of the certifications in this section.

3 X. The healthcare group program shall comply with all applicable
4 federal requirements.

5 Y. Healthcare group may pay a commission to an insurance producer. To
6 receive a commission, the producer must certify that to the best of the
7 producer's knowledge the employer group has not had insurance in the one
8 hundred eighty days before applying to healthcare group. For the purposes of
9 this subsection, "commission" means a one time payment on the initial
10 enrollment of an employer.

11 Z. On or before June 15 and November 15 of each year, the director
12 shall submit a report to the joint legislative budget committee regarding the
13 number and type of businesses participating in healthcare group and that
14 includes updated information on healthcare group marketing activities. The
15 director, within thirty days of implementation, shall notify the joint
16 legislative budget committee of any changes in healthcare group benefits or
17 cost sharing arrangements.

18 AA. For the purposes of this section:

19 1. "Accountable health plan" has the same meaning prescribed in
20 section 20-2301.

21 2. "COBRA continuation provision" means:

22 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
23 vaccines, of the internal revenue code of 1986.

24 (b) Title I, subtitle B, part 6, except section 609, of the employee
25 retirement income security act of 1974.

26 (c) Title XXII of the public health service act.

27 (d) Any similar provision of the law of this state or any other state.

28 3. "Creditable coverage" means coverage solely for an individual,
29 other than limited benefits coverage, under any of the following:

30 (a) An employee welfare benefit plan that provides medical care to
31 employees or the employees' dependents directly or through insurance,
32 reimbursement or otherwise pursuant to the employee retirement income
33 security act of 1974.

34 (b) A church plan as defined in the employee retirement income
35 security act of 1974.

36 (c) A health benefits plan, as defined in section 20-2301, issued by a
37 health plan.

38 (d) Part A or part B of title XVIII of the social security act.

39 (e) Title XIX of the social security act, other than coverage
40 consisting solely of benefits under section 1928.

41 (f) Title 10, chapter 55 of the United States Code.

42 (g) A medical care program of the Indian health service or of a tribal
43 organization.

44 (h) A health benefits risk pool operated by any state of the United
45 States.

1 (i) A health plan offered pursuant to title 5, chapter 89 of the
2 United States Code.

3 (j) A public health plan as defined by federal law.

4 (k) A health benefit plan pursuant to section 5(e) of the peace corps
5 act (22 United States Code section 2504(e)).

6 (l) A policy or contract, including short-term limited duration
7 insurance, issued on an individual basis by an insurer, a health care
8 services organization, a hospital service corporation, a medical service
9 corporation or a hospital, medical, dental and optometric service corporation
10 or made available to persons defined as eligible under section 36-2901,
11 paragraph 6, subdivisions (b), (c), (d) and (e).

12 (m) A policy or contract issued by a health care insurer or the
13 administration to a member of a bona fide association.

14 4. "Eligible employee" means a person who is one of the following:

15 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions
16 (b), (c), (d) and (e).

17 (b) A person who works for an employer for a minimum of twenty hours
18 per week or who is self-employed for at least twenty hours per week.

19 (c) An employee who elects coverage pursuant to section 36-2982,
20 subsection ~~H~~ H. The restriction prohibiting employees employed by public
21 agencies prescribed in section 36-2982, subsection ~~H~~ H does not apply to
22 this subdivision.

23 (d) A person who meets all of the eligibility requirements, who is
24 eligible for a federal health coverage tax credit pursuant to section 35 of
25 the internal revenue code of 1986 and who applies for health care coverage
26 through the healthcare group program. The requirement that a person be
27 employed with a small business that elects healthcare group coverage does not
28 apply to this eligibility group.

29 5. "Genetic information" means information about genes, gene products
30 and inherited characteristics that may derive from the individual or a family
31 member, including information regarding carrier status and information
32 derived from laboratory tests that identify mutations in specific genes or
33 chromosomes, physical medical examinations, family histories and direct
34 ~~analysis~~ ANALYSES of genes or chromosomes.

35 6. "Health benefit plan" means coverage offered by the administration
36 for the healthcare group program pursuant to this section.

37 7. "Health status-related factor" means any factor in relation to the
38 health of the individual or a dependent of the individual enrolled or to be
39 enrolled in a health plan including:

40 (a) Health status.

41 (b) Medical condition, including physical and mental illness.

42 (c) Claims experience.

43 (d) Receipt of health care.

44 (e) Medical history.

45 (f) Genetic information.

1 (g) Evidence of insurability, including conditions arising out of acts
2 of domestic violence as defined in section 20-448.

3 (h) The existence of a physical or mental disability.

4 8. "Hospital" means a health care institution licensed as a hospital
5 pursuant to chapter 4, article 2 of this title.

6 9. "Late enrollee" means an employee or dependent who requests
7 enrollment in a health benefit plan after the initial enrollment period that
8 is provided under the terms of the health benefit plan if the initial
9 enrollment period is at least thirty-one days. Coverage for a late enrollee
10 begins on the date the person becomes a dependent if a request for enrollment
11 is received within thirty-one days after the person becomes a dependent. An
12 employee or dependent shall not be considered a late enrollee if:

13 (a) The person:

14 (i) At the time of the initial enrollment period was covered under a
15 public or private health insurance policy or any other health benefit plan.

16 (ii) Lost coverage under a public or private health insurance policy
17 or any other health benefit plan due to the employee's termination of
18 employment or eligibility, the reduction in the number of hours of
19 employment, the termination of the other plan's coverage, the death of the
20 spouse, legal separation or divorce or the termination of employer
21 contributions toward the coverage.

22 (iii) Requests enrollment within thirty-one days after the termination
23 of creditable coverage that is provided under a COBRA continuation provision.

24 (iv) Requests enrollment within thirty-one days after the date of
25 marriage.

26 (b) The person is employed by an employer that offers multiple health
27 benefit plans and the person elects a different plan during an open
28 enrollment period.

29 (c) The person becomes a dependent of an eligible person through
30 marriage, birth, adoption or placement for adoption and requests enrollment
31 no later than thirty-one days after becoming a dependent.

32 10. "Preexisting condition" means a condition, regardless of the cause
33 of the condition, for which medical advice, diagnosis, care or treatment was
34 recommended or received within not more than six months before the date of
35 the enrollment of the individual under a health benefit plan issued by a
36 contractor. Preexisting condition does not include a genetic condition in
37 the absence of a diagnosis of the condition related to the genetic
38 information.

39 11. "Preexisting condition limitation" or "preexisting condition
40 exclusion" means a limitation or exclusion of benefits for a preexisting
41 condition under a health benefit plan offered by a contractor.

42 12. "Small employer" means an employer who employs at least one but not
43 more than fifty eligible employees on a typical business day during any one
44 calendar year.

1 13. "Waiting period" means the period that must pass before a potential
2 participant or eligible employee in a health benefit plan offered by a health
3 plan is eligible to be covered for benefits as determined by the individual's
4 employer.

5 Sec. 2. Section 36-2982, Arizona Revised Statutes, is amended to read:
6 36-2982. Children's health insurance program; administration;
7 nonentitlement; enrollment limitation; eligibility

8 A. The children's health insurance program is established for children
9 who are eligible pursuant to section 36-2981, paragraph 6. The
10 administration shall administer the program. All covered services shall be
11 provided by health plans that have contracts with the administration pursuant
12 to section 36-2906, by a qualifying plan or by either tribal facilities or
13 the Indian health service for Native Americans who are eligible for the
14 program and who elect to receive services through the Indian health service
15 or a tribal facility.

16 B. This article does not create a legal entitlement for any applicant
17 or member who is eligible for the program. Total enrollment is limited based
18 on the annual appropriations made by the legislature and the enrollment cap
19 prescribed in section 36-2985.

20 C. The director shall take all steps necessary to implement the
21 administrative structure for the program and to begin delivering services to
22 persons within sixty days after approval of the state plan by the United
23 States department of health and human services.

24 D. The administration shall perform eligibility determinations for
25 persons applying for eligibility and annual redeterminations for continued
26 eligibility pursuant to this article.

27 E. The administration shall adopt rules for the collection of
28 copayments from members whose income does not exceed one hundred fifty per
29 cent of the federal poverty level and for the collection of copayments and
30 premiums from members whose income exceeds one hundred fifty per cent of the
31 federal poverty level. The director shall adopt rules for disenrolling a
32 member if the member does not pay the premium required pursuant to this
33 section. The director shall adopt rules to prescribe the circumstances under
34 which the administration shall grant a hardship exemption to the
35 disenrollment requirements of this subsection for a member who is no longer
36 able to pay the premium.

37 F. Before enrollment, a member, or if the member is a minor, that
38 member's parent or legal guardian, shall select an available health plan in
39 the member's geographic service area or a qualifying health plan offered in
40 the county, and may select a primary care physician or primary care
41 practitioner from among the available physicians and practitioners
42 participating with the contractor in which the member is enrolled. The
43 contractors shall only reimburse costs of services or related services
44 provided by or under referral from a primary care physician or primary care
45 practitioner participating in the contract in which the member is enrolled,

except for emergency services that shall be reimbursed pursuant to section 36-2987. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors.

G. Eligibility for the program is creditable coverage as defined in section 20-1379.

~~H. On application for eligibility for the program, the member, or if the member is a minor, the member's parent or guardian, shall receive an application for and a program description of the premium sharing program.~~

~~I.~~ H. Notwithstanding section 36-2983, the administration may purchase for a member employer sponsored group health insurance with state and federal monies available pursuant to this article, subject to any restrictions imposed by the ~~federal health care financing administration~~ **CENTERS FOR MEDICARE AND MEDICAID SERVICES**. This subsection does not apply to members who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency in this state.

Sec. 3. Section 36-2983, Arizona Revised Statutes, is amended to read:

36-2983. Eligibility for the program

A. The administration shall establish a streamlined eligibility process for applicants to the program ~~and shall issue a certificate of eligibility at the time eligibility for the program is determined.~~ Eligibility shall be based on gross household income for a member as defined in section 36-2981. The administration shall not apply a resource test in the eligibility determination or redetermination process.

B. The administration shall use a simplified eligibility form that may be mailed to the administration. Once a completed application is received, including adequate verification of income, the administration shall expedite the eligibility determination and enrollment on a prospective basis.

C. The date of eligibility is the first day of the month following a determination of eligibility if the decision is made by the twenty-fifth day of the month. A person who is determined eligible for the program after the twenty-fifth day of the month is eligible for the program the first day of the second month following the determination of eligibility.

D. An applicant for the program who appears to be eligible pursuant to section 36-2901, paragraph 6, subdivision (a) shall have a social security number or shall apply for a social security number within thirty days after the applicant submits an application for the program.

E. In order to be eligible for the program, a person shall be a resident of this state and shall meet title XIX requirements for United States citizenship or qualified alien status in the manner prescribed in section 36-2903.03.

F. In determining the eligibility for all qualified aliens pursuant to this article, the income and resources of a person who executed an affidavit of support pursuant to section 213A of the immigration and nationality act on behalf of the qualified alien and the income and resources of the spouse, if any, of the sponsoring individual shall be counted at the time of application and for the redetermination of eligibility for the duration of the attribution period as specified in federal law.

G. Pursuant to federal law, a person is not eligible for the program if that person is:

1. Eligible for title XIX or other federally operated or financed health care insurance programs, except the Indian health service.

2. Covered by any group health plan or other health insurance coverage as defined in section 2791 of the public health service act. ~~Group health plan or other health insurance coverage does not include coverage to persons who are defined as eligible pursuant to the premium sharing program.~~

3. A member of a family that is eligible for health benefits coverage under a state health benefit plan based on a family member's employment with a public agency in this state.

4. An inmate of a public institution or a patient in an institution for mental diseases. This paragraph does not apply to services furnished in a state operated mental hospital or to residential or other twenty-four hour therapeutically planned structured services.

H. A child who is covered under an employer's group health insurance plan or through family or individual health care coverage shall not be enrolled in the program. If the health insurance coverage is voluntarily discontinued for any reason, except for the loss of health insurance due to loss of employment or other involuntary reason, the child is not eligible for the program for a period of three months from the date that the health care coverage was discontinued. The administration may waive the three month period for any child who is seriously or chronically ill. For the purposes of the waiver, "chronically ill" means a medical condition that requires frequent and ongoing treatment and that if not properly treated will seriously affect the child's overall health. The administration shall establish rules to further define conditions that constitute a serious or chronic illness.

I. Pursuant to federal law, a private insurer, as defined by the secretary of the United States department of health and human services, shall not limit enrollment by contract or any other means based on the presumption that a child may be eligible for the program.

Sec. 4. Section 36-2988, Arizona Revised Statutes, is amended to read:
36-2988. Delivery of services; health plans; requirements

A. To the extent possible, the administration shall use contractors that have a contract with the administration pursuant to article 1 of this chapter or qualifying plans to provide services to members who qualify for the program.

1 B. The administration has full authority to amend existing contracts
2 awarded pursuant to article 1 of this chapter.

3 C. As determined by the director, reinsurance may be provided against
4 expenses in excess of a specified amount on behalf of any member for covered
5 emergency services, inpatient services or outpatient services in the same
6 manner as reinsurance provided under article 1 of this chapter. Subject to
7 the approval of the director, reinsurance may be obtained against expenses in
8 excess of a specified amount on behalf of any member.

9 D. Notwithstanding any other law, the administration may procure,
10 provide or coordinate covered services by interagency agreement with
11 authorized agencies of this state for distinct groups of members, including
12 persons eligible for children's rehabilitative services through the
13 department of health services and members eligible for comprehensive medical
14 and dental benefits through the department of economic security.

15 E. After contracts are awarded pursuant to this section, the director
16 may negotiate with any successful bidder for the expansion or contraction of
17 services or service areas.

18 F. Payments to contractors shall be made monthly and may be subject to
19 contract provisions requiring the retention of a specified percentage of the
20 payment by the director, a reserve fund or any other contract provisions by
21 which adjustments to the payments are made based on utilization efficiency,
22 including incentives for maintaining quality care and minimizing unnecessary
23 inpatient services. Reserve monies withheld from contractors shall be
24 distributed to providers who meet performance standards established by the
25 director. Any reserve fund established pursuant to this subsection shall be
26 established as a separate account within the Arizona health care cost
27 containment system.

28 G. The director may negotiate at any time with a hospital on behalf of
29 a contractor for inpatient hospital services and outpatient hospital services
30 provided pursuant to the requirements specified in section 36-2904.

31 H. A contractor may require that subcontracting providers or
32 noncontracting providers be paid for covered services, other than hospital
33 services, according to the capped fee-for-service schedule adopted by the
34 administration or at lower rates as may be negotiated by the contractor.

35 ~~I. The administration and contractors shall not contract for any~~
36 ~~services or functions related to this article with a school district~~
37 ~~including contracting for the delivery of services, screening, outreach or~~
38 ~~information that involves the use of school staff and facilities. A school~~
39 ~~district may perform outreach and information activities that relate to this~~
40 ~~article.~~ THE ADMINISTRATION AND CONTRACTORS MAY COLLABORATE FOR FUNCTIONS
41 RELATED TO THIS ARTICLE WITH ENTITIES SUCH AS COMMUNITY BASED ORGANIZATIONS,
42 FAITH BASED ORGANIZATIONS, SCHOOLS AND SCHOOL DISTRICTS. Outreach and
43 information activities performed by a school district shall not reduce or
44 interfere with classroom instruction time.

1 J. The administration is exempt from the procurement code pursuant to
2 section 41-2501.

3 Sec. 5. Exemption from rule making

4 For the purposes of this act, the Arizona health care cost containment
5 system administration is exempt from the rule making requirements of title
6 41, chapter 6, Arizona Revised Statutes, for one year after the effective
7 date of this act.